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GROUP BENEFITS
REQUEST FOR BRAND NAME DRUG COVERAGE

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Extended Health Care Claims
1920 College Avenue
Regina, SK S4P 1C4

Fax: (306) 761-7101

INSTRUCTIONS

To be eligible for coverage for the brand name drug requested, there must be medical evidence indicating that a true adverse reaction has occurred. Please refer to Health Canada's Canada Vigilance Adverse Reaction Reporting form for Health Canada's definition of a true adverse reaction.

Any costs incurred for the completion of this request are the responsibility of the patient.

PART 1 - PATIENT INFORMATION

Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____
First Name Initial Last Name

Patient _____ _____ _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Date of Birth _____ Relationship to Plan Member _____
MMM/DD/YYYY

PART 2 - PHYSICIAN INFORMATION

Physician _____ _____ _____ Specialty _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone Number (_____) _____ Fax Number (_____)_____

Drug Name _____

Coverage for a brand name drug will be eligible only if the patient has experienced a substantive adverse reaction to a generic equivalent.

The adverse reaction must be reported to Health Canada and a copy of the completed Health Canada Vigilance Adverse Reaction Reporting Form must be submitted to our office.

Have you completed and sent the Health Canada Vigilance Adverse Reaction Reporting Form to Health Canada; and are you including a copy of the completed form with this request? ☐ Yes ☐ No

I hereby certify that the information provided in this request is true, complete and accurate.

Physician Signature _____ Date _____
MMM/DD/YYYY

PART 3 - PATIENT/GUARDIAN AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I authorize Co-operators Life Insurance Company (a) to use the personal information disclosed on this form, and any other personal information known to Co-operators Life Insurance Company regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

I hereby certify that the information provided in this request is true, complete and accurate.

Patient/Legal Guardian Name _____ Telephone Number (_____) _____

Signature of Patient/Legal Guardian _____ Date _____
MMM/DD/YYYY